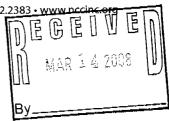


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March 14, 2008

Ms. Pat Van Buren, Program Manager Department of Health Health Regulation Administration, Long Term Care 825 North Capitol Street, NE Second Floor Washington. D.C. 20001

Dear Ms. Van Buren:

Enclosed you will find the National Children's Center's corrected application for the investigation of an accident that occurred on January 19, 2008. If you have any questions please do not hesitate to contact me.

Sincerely,

Ambus H. Harper, Jr. M.S.

Program Manager

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIN	(X3) DATE	(X3) DATE SURVEY COMPLETED	
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Administration (HF four incident report all related to the sa reports, one staff a above-listed Interm Persons with Ment involved in a "hit ar the evening of Satureturn to the facility complained of nech taken to a hospital evaluation.  On February 5, 200 facility's Incident Marevealed that sever accident, the client pain, informed staff occurred while one driving. Since then, that they had driven admitted that the stacorroborate her accident placed on unput on February 6, 2008. Coordinator faxed to facility's internal inverse February 4, 2008, in that a direct support clients to drive a facility to prepare the stage of the support clients to drive a facility to prepare the stage of the support clients to drive a facility to prepare the stage of the support clients to drive a facility to prepare the stage of the support clients to drive a facility to prepare the stage of the support clients to drive a facility to prepare the stage of the support clients to drive a facility to prepare the stage of the support clients to drive a facility to prepare the stage of the support clients to drive a facility to prepare the stage of the support clients to drive a facility to prepare the stage of the support clients to drive a facility to prepare the stage of the support clients to drive a facility to prepare the stage of the support clients to drive a facility to prepare the stage of the support clients to drive a facility to the stage of the support clients to drive a facility to the stage of the support clients to drive a facility to the stage of the support clients to drive a facility to the stage of the support clients to drive a facility to the stage of the support clients to drive a facility to the stage of the support clients to drive a facility to the stage of the support clients to drive a facility to the support clients to the support clients	108, the Health Regulation (A), or State agency, received the via fax transmittal that were ame incident. According to the and four clients of the and four clients of the and Retardation (ICF/MR) were ad run" vehicular accident on irday, January 19, 2008. Upon one of the four clients apain and was subsequently emergency room for  8, telephone interview with the anagement Coordinator al days after the vehicular who had complained of neck that the accident had of the other clients admitted the vehicle. All four client aff person had asked them to bunt. The staff person had aid administrative leave.  8, the Incident Management the State agency the stigation report, dated which the facility determined staff person had allowed two	W 000	See Response to W104		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 000 W 104	The findings and conclusions in this report were determined through interviews and record review at the facility on February 8, 2008.		W t				
	budget, and operating	must exercise general policy, g direction over the facility.					
	Based on interview a governing body providirection over the factorial direction direction over the factorial direction	not met as evidenced by: nd record review, the ded general operating ility, except for the following:					
	internal investigation 2008 revealed that the January 19, 2008, a collents to drive the fact statement on the incidence, and attempted collaborate on the fals incident Review Completinuary 5, 2008 reviews tigation, at which	ew of the incident and					
( ( ( ( (	revealed that 21 days days after the internal completed, there was governing body sough relevant components o	Jary 8, 2008 investigation after the accident, and 4 investigation was no evidence that the t to determine whether all					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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N C (	OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COD 6200 2ND STREET, NW WASHINGTON, DC 20011		/08/2008
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W 1	1. On February 8, review of the facility September 2006, in was an accident involved in the drug screening with The accident happe 2008. The staff drid January 20, 2008 a 22, 2008. It was rescreening performe 2008, more than the was first reported. February 8, 2008 in managers and qualithat they were unfarpolicies; they all staff the lab opened on a 2. On February 8, 2 facility's transportation following: "Responsion of the Service or Program Knowledge of the Incindividuals being transported ratio of staff provide adequate suffer ratio stated is 1:3 staff for every 3 individuals the group, a sepresent It is the reassure that the Direct Drivers implement the	2008, beginning at 10:08 AM, y's Transportation Policy, dated evealed that whenever there volving clients, the direct staff re accident should receive a sin 24 hours of the accident. Ened on Saturday, January 19, wer worked on Sunday, and again on Tuesday, January 23, ree (3) days after the accident at should be noted that terviews with several at assurance staff revealed miliar with that aspect of the field that staff could wait until weekday.  Oo8, further review of the bilities for assuring the safety re individuals by the Direct Staff Drivers includes: dividual Plans of the asported which specifies the fit of individual necessary to pervision. For example, if a fourth individual cond staff member must be a ponsibility of the Program to at Service and Program Staff ese rules and guidelines."	W 10	1. The staff members that indicated that they were untituded that they were untituded as spect of the policy, the Agency will reinforce the trapolicy with the staff and the by 3/31/08. Any staff members authorization to drive an Agency treview the transportation particular incident occurred Saturday night (a weekend Monday holiday MLK holidathat the staff members who considered the time the incidence occurred (a weekend night) the knowledge that the upcomonday was a holiday, the staff members who can gefore the laboratory on a weekday after the holid Agency's Human Resources Department is exploring with determine whether there are who can provide services 24 hours/seven days per week. The vendors that will accommand agency, then the Agency will policy to reflect a specified time for example, the policy migh and staff tested within 24 accident or the next business accident is on the weekend of the policy must be modified the occur by 04/15/08	familiar with en the insportation managers er who gains ency vehicle on policy. It is likely responded dent and having ming staff knew obtain reopened ay. The  Labs to vendors  If there are odate the modify its me period. It say I hours of it day if r holiday. If nis will	03/31/08
	clients' Individual Sur	10 PM review of the four opport Plans (ISPs) revealed		2. The staffing ratios are conevery activity that is planned.	In this	

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	staff-to-client ratio be while on community ratio prescribed). To investigation had destaff with four clients interview with the experience with the experience of that a direct reportedly informed staff person who was out in the commodither the direct surface of the vehicle with form the vehicle with the Form the program dender the program dender the stack of the shift super concern about the stack of the facility's Incident documented a February incident and internal IRC's findings and reservice of the program and reservice that manager than the program and t	and #4 were prescribed 2.4 between 7 AM - 10 PM and routings (Client #1 had a 2.8 he facility's internal etermined that there was one s. At 12:22 PM, telephone rening shift supervisor ct support staff person him that his co-worker (the is involved in the accident) hunity with four clients. upport staff nor the supervisor choned the staff driver by cell etermining that she was alone for clients. February 8, 2008 Program Manager, list and Incident Management as review of the internal revealed that staff-to-client discussed or evaluated at the or since then. At 12:34 PM, er acknowledged that he was that the direct support staff rvisor on duty had expressed affing ratio at the time of the scribed staffing ratios had not the Review Committee (IRC) liary 5, 2008 review of the investigation. Review of the investigation. Review of the commendations revealed no lement sought to determine coribed staff-to-client ratios	W 104	accident did not follow the suprinstruction and the staff that rethe facility accepted their colleasuggestion without checking the and soundness of it with their supervisor. Therefore, the supervisor is the activity alone was not notified that the employeaving to do an activity alone was not notified that the employeaving to do an activity alone was not notified that the employment of the individual in the accident as of 2/06/08. The will continue to reinforce each somember regarding their responsibility/obligation of report their supervisor any situation the part approximation of the next official occurrence will staff meeting held on 3/19/08. It is indicated in an earlier answer that indicated in an earlier answer the client staff ratios will be reviewed by 3/31/08.  It is indicated in an earlier answer the client staff ratios will be reviewed by 3/31/08.  It is indicated in an earlier answer the client staff ratios will be reviewed by 3/31/08.  It is indicated in an earlier answer the client staff ratios will be reviewed by 3/31/08.  It is indicated in an earlier answer that the approvided false statements to the supervisor and on the incident of the supervisor and on the incident of the post accident drug screening set to occur on the first available that the lab was to be open and employee never returned to wor	mained at ague's e validity ervisor yee was without The d the volved in Agency staff rting to at might cluding ions is given as istent usly but be at the he staff is er that ewed. iew orted the ployee eports. Ig was e date the	02/06/08
DIA CAME OFFI	7(02-99) Pravious Versions O	hsolete Event ID: 95/11/1	Eggilib	policy might need to be modified it accommodates the weekends holidays, times when traditional businesses that would do drug	l so that	

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	Administration (HRA reports via fax trans the same incident. staff and four reside Intermediate Care F Mental Retardation "hit and run" vehicul Saturday, January 1 facility, one of the for neck pain and was shospital emergency  On February 5, 2008 facility's Incident Marevealed that several accident, the resider neck pain, informed occurred while one obeen driving. Since admitted that they have sidents admitted that sked them to corrol	28, the Health Regular A) received four incide mittal that were all refrected for the represents of the above-lister accident on the events of the above-lister accident on the events of the complaint of the other residents and days after the vehical days after the vehical two had complaint the other residents then, two other residents then, two other residents then the staff person hours and been place of the other account of the staff person hours and been place of the other account of the staff person hours and been place of the other account of the staff person hours and the staff person hours are the staff person had been place	ent elated to orts, one ed ith /ed in a /ening of n to the ned of or eular ed of it had had ents All four ad f a hit	1000			
i i v	Coordinator faxed to nvestigation report, on which the facility detected allow a cility vehicle.  On February 8, 2008,	the Incident Manag HRA the facility's inte dated February 4, 200 ermined that a direct wed two residents to HRA initiated an one mine compliance with	ernal 08, în support drive a			·	
fe to s	ederal and local stan o prescribed staffing afety while being tra he findings and con-	mine compliance with re ratios and ensuring in the commodusions in this report	spect resident nunity.				
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	determined through at the facility on Feb	interviews and recor cruary 8, 2008.	d review				
1 500	3523.1 RESIDENT	S RIGHTS		I 500	C		
	that the rights of res protected in accorda chapter, and other a laws.	ence director shall endents are observed ance with D.C. Law 2 applicable District and	and -137, this I federal	ĺ	1. The staff members that resindicated that they were unfamithis aspect of the policy, then the Agency will reinforce the transpectory with the staff and the marks 2/24/2020.	liar with e ortation nagers	03/31/08
	This Statute is not r Based on interview a failed to ensure the r in the community an supervision at the le Individual Support P.	and record review, th residents' right to saf d right to receive stat vels prescribed in his	e facility e travel ff	by 3/31/08. Any staff member w authorization to drive an Agency must review the transportation p All managers also are made aw the Agency's transportation polic particular incident occurred on a Saturday night (a weekend prec			
	The findings include:				Monday holiday MLK holiday). It that the staff members who resp considered the time the incident	onded	
	<ol> <li>Residential progra failed to ensure that ratios were implement residents' annual pla</li> </ol>	prescribed staff-to-re nted, in accordance v	sident		occurred (a weekend night) and the knowledge that the upcomin Monday was a holiday, the staff that the employee could not obta	having g knew ain	
	On February 8, 2008 review of the facility's dated September 20	Transportation Police Transportation Police 106, revealed the follo	cies, wing:		testing before the laboratory reo on a weekday after the holiday. Agency's Human Resources Department is exploring with Lat	The os to	
1	"Responsibilities for a supervision of the ind Service or Program S Knowledge of the Ind ndividuals being tran required ratio of staff provide adequate sup	lividuals by the Direc Staff Drivers includes lividual Plans of the sported which specif to individual necess	t : ies the ary to		determine whether there are ver who can provide services 24 hours/seven days per week. If the no vendors that will accommoda Agency, then the Agency will mo policy to reflect a specified time per For example, the policy might sa	iere are te the odify its period.	04/15/08
t s j	he ratio stated is 1:3 staff for every 3 indivious the group, a seconesent It is the resion Administration	, this means there miduals If a fourth in the staff member m	ust be 1 dividual ust be	·	and staff tested within 24 ho accident or the next business da accident is on the weekend or ho the policy must be modified this occur by 04/15/08.	ours of y if oliday. If	

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		assure that the Direct Drivers implement the	ot Service and Progr nese rules and guide	am Staff lines."					
Alth Realth and Alth Realth and Alth Realth and Alth Realth and Although and Althou	the second of th	At approximately 12: residents' Individual revealed that Reside prescribed 2:4 staff-t AM - 10 PM and whill (Resident #1 had a 2 facility's internal invest there was one staff w PM, telephone intervisupervisor revealed tiperson reportedly info (the staff person who accident) was out in the supervisor took action driver by cell phone, eache was alone in the vertice of the was alone in the vertice was alone in the time of the was alone in the time of the was alone at the direct support upervisor on duty had not be staffing ratio at the mat the direct support upervisor on duty had not staffing ratio at the mat prescribed staffing aplemented.  The facility failed to exceed the was alone with their The February 8, 2008, but a Administration	10 PM review of the Support Plans (ISPs shts #2, #3 and #4 who-resident ratio between community out it.8 ratio prescribed). It is ratio prescribed. It is ratio prescribed it is ratio prescribed. It is ratio prescribed it is ratio prescribed. It is ratio prescribed it is a direct support or med him that his community with first a direct support staff it (i.e. telephoned the etc.) after determining the program with the Program Wanager was previously unay staff and/or the shift it expressed concern time of the accident it ratios had not been discussed in the accident it ratios had not been discontant in the direct coldent received a division of the accident, in transportation Policy fransportation Policy	four ) ere /een 7 ings The ined that at 12:22 shift staff b-worker our nor the e staff g that dents. ram lent ew of hat ssed or nce vare about , or		2. The staffing ratios are considerevery activity that is planned. In the instance the staff involved in the accident did not follow the supervinstruction and the staff that remathe facility accepted their colleagus suggestion without checking the vand soundness of it with their supervisor. Therefore, the superviwas not notified that the employee leaving to do an activity alone with the assistance of a co-worker. The Agency has officially terminated the employment of the individual involute accident as of 2/06/08. The Agwill continue to reinforce each staff member regarding their responsibility/obligation of reporting their supervisor any situation that ribe a potential safety hazard (including staffing patterns) as well as actions contrary to directions/instructions given a supervisor or actions inconsist with the Agency's policies. This will be reiterated continuously the next official occurrence will be a staff meeting held on 3/19/08. In addition the agency will review the staff of three of the individuals involved by 3/31/08.	his isor's ined at ue's validity isor was nout e ne ved in uency f g to might ding s iven tent but at the	02/06/08	

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		review of the facility dated September 2 there was an accided direct staff driver in receive a drug screaccident. The incid January 19, 2008. Sunday, January 20, 2008, Industry 23, 2008, Industry 24, 2008, Industry 25, 2008, Industry 26, 200	y's Transportation Po 006, revealed that went involving resident volved in the accider ening within 24 hours lent happened on Sa The staff driver work 0, 2008 and again on It was reported that stormed on Wednesda more than three (3) distributed in the stormed on went end est reported. It should a stormed on the surrance vere unfamiliar with the significant that ab opened on a weet that aspects of the factions were not implementary 19, 2008 incident	henever is, the it should is of the it should is of the furday, ed on Tuesday, she had a ay, ays after if be with e staff it staff kday cility's ented at it, or it y faff driver ent scene red. She Review ed is facility in report, ctice. it staff ay, January primand	I 500	3. a. The Agency's invest based upon what the staff reported to the Supervisor of the accident. At that poinothing to suggest that the happen as reported. The sreported that the vehicle shit by another driver who sleft the seen. This situation put her in an unknown are with the safety of the other consider. The employee wher word. It was not until la of the other individuals car reported something differency's management, up different version of the accinformed the incident manathe steps to place the employee never returned the new version of the accinformed. Disciplinary action have occurred until the interinvestigation was complete investigation was complete reviewed on 2/05/08 and the was terminated effective 2/0 Disciplinary action was recompleted.	member on the night nt there was e event did not staff member he was in was sped off and n would have a, after dark, individuals to as taken at ater when one ne forth and nt. The con hearing a ident, ager and took loyee on ever, the o work after dent ons would not emal ad. The d and ne employee 06/08.	2/06/08	
Hea	ith Regulat	tion Administration	<del>- · · . <u>-</u></del>			and swift action was taken.	<u>,</u>		

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	b. On February 8, 2 transportation policy uses a facility vehicle the community mus Log' entry on the da 2008, interviews with that the direct staff of transportation log or facility's internal invested direct staff driver wo January 20, 2008 ar	2008, review of the fay revealed that any side for transporting clicate for transporting clicate of use. On February 19, 2008. It is an as noted above or day and as noted above or day any 19, 2008. It is an an as noted above or day and as noted above or day and as noted above or day and again on Tuesday the for failing to use the ar evidence that the ying a working cell problem of the day of t	taff who ents in ortation ary 8, evealed omplete a The not the insurance of the even some 2008 to	1500	b. The Agency is currently the program drivers complet transportation log.  c. The driver did have a worphone at the time of the accinternal investigation concluemployee provided a false revent. It is assumed by defire report as false that the NCC transportation policy was not a second to the content of t	king cell ident. The ded that the eport of the ning the	3/12/08
alth Rogulal	tion Administration						· 